Supreme Court, U.S.
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No. 10 - _____

IN THE
Supreme Court of the United States

RODNEY MILLER,

Petitioner,

v.

MONUMENTAL LIFE INSURANCE COMPANY,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Can an ERISA insurer, after denying an ERISA claim on one basis at the administrative level, assert a new defense on appeal to the District Court?

RULE 14.1(b) STATEMENT

A list of all parties to the proceeding in the court whose judgment in the subject of the petition is as follows:

Plaintiff/Appellant and Petitioner: Rodney Miller

Defendant/Appellee and Respondent: Monumental Life Insurance Company

TABLE OF CONTENTS

OPINIONS BELOW 1

JURISDICTION 1

STATUTORY PROVISION INVOLVED 1-2

STATEMENT OF THE CASE 2

REASONS FOR GRANTING THE WRIT 7

CONCLUSION 21

APPENDIX

District Court Opinion
(March 31, 2009) 1

Court of Appeals Opinion
(April 28, 2010) 85

TABLE OF AUTHORITIES

CASES **Page**

Crull v. Gem Ins. Co.,
58 F.3d 1386 (9th Cir. 1995) 16

Flinders v. Workforce Stabilization Plan of Phillips Petroleum Co.,
491 F.3d 1180 (10th Cir. 2007) ..... 10, 11 ,12

Franchise Tax Board v. Construction Laborers Vacation Trust,
463 U.S. 1 (1983) 8

Glass v. United of Omaha Life Ins. Co.,
33 F.3d 1341 (11th Cir. 1994) 16

Hall v. Metro. Life Ins. Co.,
259 F. App'x 589 (4th Cir. 2007) (unpublished)
..... 17

Hall v. UNUM Life Insurance Co. of America,
300 F.3d 1197 (10th Cir. 2002) 17, 18

Hillstrom v. Kenefick,
484 F.3d 519 (8th Cir. 2007) 12, 13

Jewell v. Life Ins. Co. of N. Am.,
508 F.3d 1303 (10th Cir. 2007) 19

Juliano v. Health Maint. Org. of N.J., Inc.,
221 F.3d 279 (2d Cir. 2000) 17

TABLE OF AUTHORITIES
(continued)

CASES **Page**

King v. Hartford Life and Accident Ins. Co.,
414 F.3d 994 (8th Cir. 2005) 10

Lauder v. First Unum Life Ins. Co.,
284 F.3d 375 (2nd Cir. 2002) 14, 15

Marolt v. Alliant Techsystems,
146 F.3d 617 (8th Cir. 1998) 13

Massachusetts Mut. Life Ins. Co. v. Russell,
473 U.S. 134 (1985) 9

Metropolitan Life Insurance Co. v. Glenn,
554 U.S. 105 (2008) 16, 17

Perry v. Simplicity Engineering,
900 F.2d 963 (6th Cir. 1990) 20

Pitts v. American Sec. Life Ins. Co.,
931 F.2d 351 (5th Cir. 1991) 15, 16

Quesinberry v. Life Ins. Co. of N. Am.,
987 F.2d 1017 (4th Cir. 1993) 18, 19

Sandoval v. Aetna Life and Cas. Ins. Co.,
967 F.2d 377 (10th Cir. 1992) 10, 11

Short v. Central States, S.E. & S.W. Areas Pension Fund,
729 F.2d 567 (8th Cir. 1984) 8

TABLE OF AUTHORITIES
(continued)

CASES **Page**

Thomason v. Aetna Life Ins. Co.,
9 F.3d 645 (7th Cir. 1993) 16

Thompson v. Life Ins. Co. of N. Am.,
30 F. App'x 160, 164 (4th Cir. 2002) (unpublished)
..... 17

White v. Provident Life & Accident Ins. Co.,
114 F.3d 26 (4th Cir. 1997) 16

Winebarger v. Liberty Life Assur. Co.,
571 F. Supp. 2d 719 (D.W.Va. 2008)
..... 16, 17

STATUTES AND REGULATIONS

29 U.S.C. § 1133(1) 9, 10, 11

29 C.F.R. § 2560.503-1(g)(i-iv) 9, 10

PETITION FOR WRIT OF CERTIORARI

Petitioner Rodney Miller respectfully petitions for a writ of certiorari to review the opinion and judgment of the United States Court of Appeals for the Tenth Circuit.

OPINIONS BELOW

The decision of the United States Court of Appeals for the Tenth Circuit is unpublished but reported at 2010 U.S. App. LEXIS 8795 and is reproduced in the appendix at pages 85-93. The decision of the United States District Court for the District of New Mexico is unpublished but reported at 2009 U.S. Dist. LEXIS 43859 and is reproduced in the appendix at pages 1-83.

JURISDICTION

The judgment of the court of appeals sought to be reviewed was issued on April 28, 2010. The petition is timely under Supreme Court Rule 13.1 because it is being filed within 90 days after the entry of the court of appeals' opinion and judgment. This Court has jurisdiction to review the judgment of the United States Court of Appeals for the Tenth Circuit pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

§ 1133. Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall--

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

STATEMENT OF THE CASE

The issue presented is whether the Defendant/Respondent Monumental Life Insurance Company can raise a new defense to an ERISA claim for the first time on appeal to the District Court.

On September 15, 1997, Petitioner Rodney Miller ("Miller") was injured in motor vehicle accident while in the course and scope of his employment with Aycock Transportation. Subsequently, Petitioner filed a claim for Long-Term Disability ("LTD") benefits under ERISA policy issued by Respondent Monumental Life Insurance Company. ("Monumental"). As required by the terms of the policy, Miller filed a disability claim with the Social Security Administration. After a hearing, the Administrative Law Judge determined that

Miller was disabled under Title XVI of the Social Security Act. After receiving the decision, Monumental nevertheless denied Miller's claim on the basis that it was not a "Social Security Disability Award" The denial letter read in full as follows:

> Based on a review of your policy terms it does not appear that you are eligible for continuous total disability.
>
> According to the terms of the policy in order to be eligible for continuous total disability you must be unable to engage in any gainful employment for which you can be reasonably trained for [sic].
>
> You must be awarded a social security disability award for injuries sustained from this accident of 9-15-97. The information you have provided to us from the social security office is for supplemental security income and not a social security disability award. Therefore, no benefits are available.

Thus, according to Monumental, and despite the absence of any differentiating language in the policy, Miller was required to obtain a Social Security Disability Award under Title II of the Social Security to meet the

disability requirements of the policy and because the decision of the Social Security Administrative Law Judge was under Title XVI, Miller was denied LTD benefits.

Miller appealed the denial to the United States District for the District of New Mexico and subsequently moved for Summary Judgment. Monumental filed a Cross-Motion for Summary Judgment, asserting for the first time on appeal that, in addition to the alleged failure to obtain a "Social Security Disability Award,: Miller's disability did not result "solely and directly from Injury" as set out in the policy. Prior to the District Court appeal, Monumental never asserted this policy defense to Miller.

On June 30, 2005, the District Court entered summary judgment in favor of Monumental, holding that the Social Security Administration's determination of disability under Title XVI of the Social Security Act did not constitute a "Social Security Disability Award" under the policy. The District Court did not address Monumental's newly-raised "sole cause" defense, determining that it "need not decide whether the other grounds that Monumental advances also preclude payment."

Miller appealed to the United States Court of Appeals to the Tenth Circuit. After receiving the parties' briefs, the appeals court ordered supplemental briefing on six specific questions and *sua sponte* determined that oral argument should be held. On September 25, 2007, the

Tenth Circuit reversed the decision of the District Court, holding that Miller met the policy requirement that he obtain a "Social Security Disability Award." However, the Tenth Circuit ordered a remand because the District Court did not address Monumental's argument that Miller's accident was not the sole cause of his disability.

On the sole cause remand, the District Court allowed supplemental briefing and held oral arguments over Miller's objections that the sole cause issue was untimely and its application would not change the outcome. On March 31, 2009, the District Court ordered a remand to the Plan Administrator to allow Monumental to develop the "sole cause" defense that it first asserted at the District Court appeal. According to the District Court:

> The problem in this case is that the Plan Administrator gave only one basis for denying benefits and was silent on the other elements of the Policy. The record does not reflect that the Plan Administrator determined whether the work injury was the sole cause of the disability or whether she believed evidence on that element was lacking. Until the Plan Administrator clarifies at what evidence it looked on the sole cause and other elements, the Court cannot review what the

> Plan Administrator did in a meaningful way.

Miller v. Monumental Life, 2009 U.S. Dist. LEXIS 43859 at 91-92, App. at 60 (D.N.M. 2009).

In response to this decision, Miller filed a second appeal to the Tenth Circuit, raising the issue of whether Monumental was permitted to raise a defense for the denial of an ERISA claim for the first time at the District Court level. On April 28, 2010, the Tenth Circuit held that due to a lack of finality, it lacked jurisdiction to review the decision of the District Court to remand the "sole cause" issue to the Plan Administrator. According to the Tenth Circuit,

> While it is conceivable that Miller may ultimately convince either this court or the district court that Monumental was barred from raising the 'sole cause' defense, the fact that he must wait to do so until proceedings on remand are complete does not make the issue effectively unreviewable."

Miller v. Monumental Life, 2010 U.S. App. LEXIS 8795 at 8; App. at 6-7 (10th Cir. 2010).

This Petition followed.

REASONS FOR GRANTING THE WRIT

The Petition should be granted because the decision creates a clear circuit conflict and allows an insurer to circumvent ERISA protections by asserting a new defense for the first time at the district court level and then claim it is entitled to a remand to the Plan Administrator because the defense has not been developed. The decision of the Tenth Circuit is in conflict with not only its own prior decisions, but with the decisions of numerous other circuits that refuse to permit an ERISA insurer to deny a claim on one basis at the administrative level and assert an additional or new defense to its denial of an ERISA claim during the appeal to the District Court. Rather, prior decisions that allow remand for development of evidence are for cases with a record of the defense already asserted prior to the appeal. This Court should finally resolve this issue, and refuse to allow an ERISA insurer to deny an ERISA claim on one basis at the administrative level and subsequently assert a new defense on appeal to the district court.

As it currently stands, an insurer may wait until federal court litigation is commenced before complying with ERISA requirements that it give notice to a claimant of its reasons for denying a claim and providing a claimant a fair opportunity to dispute the denial at the administrative level. Given this precedent, there is little doubt an insurer's counsel will advise their client that it can have a second chance if during the administrative process it omits a potentially

legitimate defense and saves it for an appeal. This creates an exception to the rule that no new issues may be raised on appeal. Furthermore, it assures that future ERISA claimants will suffer the burdens of additional delays and expenses as a case can now be remanded after a decision on the merits to allow an insurer to assert the untimely-raised defense. Ultimately, it defeats the central purpose of ERISA, which is the speedy and cost-effective resolution of claims.

From the inception of ERISA, it has always been intended that a federal common law of ERISA would be developed to assure consistency in ERISA decisions. The United States Supreme Court first enunciated this view of federal courts' power to create federal common law under ERISA in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983) (superseded on other grounds), based upon the often-repeated assertion upon a statement by Senator Javits, one of ERISA's sponsors, that "[a] body of federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." 120 Cong. Rec. S29942 (statement of Sen. Javits). In addition to consistency of application, ERISA and its accompanying regulations have always been intended to help claimants process their claims efficiently and fairly and were not intended to be used by an insurer as a smoke screen to shield itself from legitimate claims. *Short v. Central States, S.E. & S.W. Areas Pension Fund*, 729 F.2d 567, 575 (8th Cir. 1984). In deciding ERISA cases, the ultimate consideration is "whether

allowance or disallowance of particular relief would best effectuate the underlying purposes of ERISA -- enforcement of strict fiduciary standards of care in the administration of all aspects of pension plans and promotion of the best interests of participants and beneficiaries." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 158, 87 L. Ed. 2d 96, 105 S. Ct. 3085 (1985) (Brennan, J., concurring).

ERISA regulations provide that the plan administrator must provide a claimant with written or electronic notification of an adverse benefits determination in a manner calculated to be understood by a claimant, as follows:

> (i) The specific reason or reasons for the adverse determination;
>
> (ii) Reference to the specific plan provisions on which the determination is based;
>
> (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
>
> (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a

> civil action under section 502(a) of the Act following an adverse benefit determination on review[.]

See 29 C.F.R. § 2560.503-1(g)(i-iv); *see also* 29 U.S.C. § 1133(1).

The Tenth Circuit has refused to permit an ERISA insurer to assert a new defense at the District Court level. In *Flinders v. Workforce Stabilization Plan of Phillips Petroleum Co.*, 491 F.3d 1180 (10th Cir. 2007), in reviewing a denial of benefits under the more deferential "arbitrary and capricious" standard, the Tenth Circuit explained:

> In reviewing a plan administrator's decision, we may only consider the evidence and arguments that appear in the administrative record. *Sandoval v. Aetna Life and Cas. Ins. Co.*, 967 F.2d 377, 380 (10th Cir. 1992); *see also King v. Hartford Life and Accident Ins. Co.*, 414 F.3d 994, 999 (8th Cir. 2005) ("[A] reviewing court must focus on the evidence available to the plan administrators at the time of their decision and may not admit new evidence or consider post hoc rationales"). This means that, when reviewing a plan administrator's decision to deny benefits, we consider only the

> rationale asserted by the plan administrator in the administrative record ...

Id. at 1190.

The Tenth Circuit further explained, "[t]o determine whether a plan administrator considered and asserted a particular rationale, we look only to those rationales that were specifically articulated in the administrative record as the basis for denying a claim." *Id.* at 1190-91 (citing 29 U.S.C. § 1133(1) (noting that a claim denial must "set[] forth the specific reasons for such denial, written in a manner calculated to be understood by the participant") (emphasis in original). The Tenth Circuit then explained:

> The reason for this rule is apparent – "[w]e will not permit ERISA claimants denied the timely and specific explanation to which the law entitles them to be sandbagged by after-the-fact plan interpretations devised for purposes of litigation." This is consistent with the converse rule that a claimant may not urge new grounds outside the administrative record that would support the award of benefits.

Id. at 1191 (citations omitted).

In sum, the Tenth Circuit in *Flinders* refused to allow the Plan to assert a new defense at the district court level, holding that if it were to allow this, "a plan administrator could simply treat the administrative process as a trial run and offer a post hoc rationale in district court. In addition, such a practice would result in an incomplete administrative record." *Id.*

Given the Tenth Circuit precedent and principles enunciated, it is questionable how the District Court found it could remand for a new issue, and frustrating that the appeals court will not determine the merits of this remand order now and stop the litigation. Rather this issue is eluding review on the merits due to its apparent conflict with another rule on appeal, finality of judgment. Miller urges that this Tenth Circuit holding defeats the rule because it allows litigation of the new issue on appeal to return back to the Plan Administrator, even if there is no basis to allow remand because it is a new issue. The ultimate correct outcome to apply the rule of no new issues on appeal after allowing the new issue and full remand results in a futile and expensive delay as the new litigation should have never occurred.

The Eighth Circuit does not allow ERISA insurers to assert new defenses on appeal from the decision made at the administrative level.[1] In

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[1] In *Hillstrom v. Kenefick*, 484 F.3d 519 (8th Cir. 2007), the Eighth Circuit noted that under *de novo* review of a denial of benefits, a district court "must consider all of the provisions of the policy in question if those provisions are

Marolt v. Alliant Techsystems, 146 F.3d 617, 620 (8th Cir. 1998), the plan administrator did not provide a rationale for its denial of an ERISA claim at the administrative level but presented a basis for the denial for the first time on appeal to the district court. The Eighth Circuit held that the failure to provide a rationale at the administrative level "was contrary to the ERISA statute, federal regulations, and this court's longstanding precedent." *Id.* at 628 (citations omitted). Moreover, in refusing to consider a rationale that was first asserted at the district court level, the Eight Circuit explained that it would not "permit ERISA claimants denied the timely and specific explanation to which the law entitles them to be sandbagged by after-the-fact plan interpretations devised for purposes of litigation" and noted it was "free to ignore ERISA plan interpretations that did not actually furnish the basis for a plan administrator's benefits decision." *Id.* (citation omitted).

The Second Circuit has held that "an [ERISA] insurer is deemed, as a matter of law, to have intended to waive a defense to coverage where other defenses are asserted, and where the insurer possesses sufficient knowledge (actual or

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proffered to the trial court as a reason for denial of coverage, even where not relied upon by the plan administrator at the time the denial was made." *Id.* at 528 (internal quotation marks omitted). However, the Eighth Circuit specifically noted in *Hillstrom* that "after-the-fact interpretations are not at issue here." *Id.* Indeed, the court found, "[n]othing of substance has been advanced in the litigation that was not raised in the administrative process." *Id.* at 527.

constructive) of the circumstances regarding the unasserted defense." *Lauder v. First Unum Life Ins. Co.*, 284 F.3d 375, 382 (2nd Cir. 2002). In *Lauder*, the appeals court explained that the ERISA insurer knew of the claimant's claim of disability, chose not to investigate it, and chose not to challenge it and therefore waived its right to rely on lack of disability as a defense to the claim. *Id.* Furthermore, the appeals court explained that the ERISA insurer was not in the position of having to imagine every conceivable basis for denying the claim; it had all the evidence of disability before it, and could easily have evaluated that evidence to assert a lack of disability defense. *Id.* Moreover, the appeals court explained that:

> [T]his case raises the concern that plan administrators ... will try the easiest and least expensive means of denying a claim while holding in reserve another, perhaps stronger, defense should the first one fail. In light of ERISA's remedial purpose of protecting plan beneficiaries, we are unwilling to endorse manipulative strategies that attempt to take advantage of beneficiaries in this manner...[the ERISA insurer] here chose to proceed on the questionable -- but cheapest -- argument of lack of coverage when it could easily have investigated the merits of [the]

> claim. It should not now get another proverbial bite at the apple.

Id.

Despite this strong pronouncement, the Second Circuit was unwilling to announce a bright line rule to incorporate into the federal common law of ERISA. The court stated:

> Our analysis of the facts presented here leads us to conclude that principles of waiver are appropriately applied in this case. Because we do not consider this the appropriate set of facts on which to create a federal common law doctrine of waiver in the ERISA context, we limit our holding to the circumstances of this particular claim.

Id. at 382.

The Fifth Circuit has found waiver in an ERISA case after "focusing on the unilateral action of the insurer in failing to raise at the outset a known defense to the claim." *Pitts v. American Sec. Life Ins. Co.*, 931 F.2d 351, 357 (5th Cir. 1991). According to the court, "[t]he doctrine of waiver is already an important component of insurance law," using the example that "an insurer automatically waives the terms

of a policy if it defends an insured without a reservation of its rights." *Id.* (citations omitted).

Other circuits have left open the larger question of whether waiver might apply in the ERISA context while concluding that it did not in the specific case. *See Glass v. United of Omaha Life Ins. Co.*, 33 F.3d 1341, 1348 (11th Cir. 1994); *Thomason v. Aetna Life Ins. Co.*, 9 F.3d 645, 650 (7th Cir. 1993). The Fourth Circuit has reached the opposite conclusion, holding that "the federal common law under ERISA . . . does not incorporate the principles of waiver and estoppel." *White v. Provident Life & Accident Ins. Co.*, 114 F.3d 26, 29 (4th Cir. 1997); *see also Crull v. Gem Ins. Co.*, 58 F.3d 1386, 1390-91 (9th Cir. 1995) (holding that state law claims of waiver are preempted under ERISA).

A prime example of the problems faced by federal courts operating without a consistent and uniformly applied rule can be seen in *Winebarger v. Liberty Life Assur. Co.*, 571 F. Supp. 2d 719 (D.W.Va. 2008). Reviewing the denial of benefits under the "arbitrary and capricious" standard, which is by nature much more deferential to the plan administrator's decision as opposed to a *de novo* standard of review, the district court reversed the denial of benefits to a claimant and took issue with the insurer taking "inconsistent positions by encouraging the claimant to seek social security benefits, and then ignoring the finding of the Social Security Administration that the claimant was disabled from any employment." *Id.* at 725 (*citing Metropolitan Life Insurance Co.*

v. Glenn, 554 U.S. 105 (2008)). After explaining the inconsistencies and conflicts of the insurer in denying long term disability benefits, the court reversed the denial of benefits and awarded judgment to the claimant. *Id.* at 726-27. The court further noted that "[w]hile there is no binding precedent in this circuit, there are unpublished opinions holding that only the plan administrator's initial grounds of denial will be considered by the court as justification for withholding benefits, and not any later rationale relied upon in an administrative appeal, in order to prevent beneficiaries from being 'sandbagged by post-hoc justifications of plan decisions.'" *Id.* at 726, fn. 8 (*citing Hall v. Metro. Life Ins. Co.*, 259 F. App'x 589, 593 (4th Cir. 2007) (unpublished) (*quoting Juliano v. Health Maint. Org. of N.J., Inc.*, 221 F.3d 279, 287 (2d Cir. 2000)); *Thompson v. Life Ins. Co. of N. Am.*, 30 F. App'x 160, 164 (4th Cir. 2002) (unpublished).

Several circuits already prohibit supplementation of the record except in when exceptional circumstances are present. In *Hall v. UNUM Life Insurance Co. of America*, 300 F.3d 1197 (10th Cir. 2002), the Court explained "it is the unusual case in which the district court should allow supplementation of the record." *Id.* at 1202. The *Hall* court further explained that "[t]he Court should address why the evidence was not submitted to the Plan Administrator [and] it should only admit the evidence if the party seeking to introduce it can demonstrate that it could not have been submitted to the plan administrator at the time the challenged decision

was made." *Id.* at 1203. The *Hall* court further adopted the standard set in *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1021-27 (4th Cir. 1993) (en banc), which held that to allow supplementation of the record,

> A party seeking to introduce evidence from outside the administrative record bears a significant burden in establishing that he may do so. In particular, (1) the evidence must be "necessary to the district court's de novo review"; (2) the party offering the extra-record evidence must "demonstrate that it could not have been submitted to the plan administrator at the time the challenged decision was made"; (3) the evidence must not be "[c]umulative or repetitive"; nor (4) may it be "evidence that 'is simply better evidence than the claimant mustered for the claim review.'"

Id. at 1203 (*quoting Quesinberry*, 987 F.2d at 1027).

In remanding the case to the Plan Administrator, the District Court has allowed Monumental to assert a new defense raised for the first time by its counsel on appeal, something that is prohibited in every other form of

litigation.[2] ERISA rules already in place contemplate the disallowance of an insurer raising a new defense on appeal to the District Court, just as the rules contemplate denying a claimant the ability to seek a remand to the Plan Administrator to present better evidence. *See id.* Unfortunately, and in contradiction to Congress' purpose that federal courts develop uniformity in ERISA cases, the varied decisions in the circuits has prevented the implementation of a bright-line rule that would prohibit ERISA insurers from denying a claim on one basis at the administrative level and subsequently asserting a new basis for denial during the district court appeal.

What has occurred in this case can be expected to be repeated countless times in the future. Such delays and increased burdens on ERISA claimants result in a Catch-22, where an error is made in ordering remand, but despite the error, the remand must occur before the error of remanding in the first instance can be rectified.

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[2] The District Court's ruling also misapprehends the limited scope of remand by allowing a new defense advanced by Monumental's attorneys for the first time on appeal. Remand is only permitted to allow additional evidence related to or "clarification" of an existing defense. *See e.g. Jewell v. Life Ins. Co. of N. Am.*, 508 F.3d 1303, 1308 (10th Cir. 2007) ("[c]onfining review in general to the administrative record, and thus encouraging the parties to develop the factual record as fully and as early as possible, is important for a variety of reasons related to the goals of ERISA"). The District Court did not cite any exceptional circumstances to explain why it would allow Monumental to assert a new defense on appeal.

Congress certainly did not intend this result in enacting ERISA. Rather, ERISA was designed to ensure the speedy and cost-effective resolution of claims as part of the balance of protecting insureds and providing insurers with protections if ERISA's strict rules are followed. *See e.g. Perry v. Simplicity Engineering*, 900 F.2d 963, 966 (6th Cir. 1990) (court refused to interpret the *de novo* standard of review to allow a district court to consider new evidence, which was not before the fiduciary insurance company, because "such a procedure would frustrate the goal of prompt resolution of claims by the fiduciary under the ERISA scheme").

The issue presented to this Court is whether to hold insurers and Plan Administrators accountable to ERISA's statutes and regulations regarding notice and consideration of disability claims evidence and policy application at the administrative level, or allow new matters after the denial and appeal to the federal court. The Tenth Circuit in this case decided to enforce its own rule citing finality as a reason not to enforce the rule that no new defenses can be raised on appeal. The real effect of the District Court's decision to remand and the Tenth Circuit's refusal to prohibit the assertion of the new defense at this stage is to place the substantial burdens of litigation on claimant Miller while allowing Monumental, who is in a much better position to handle the significant costs and expenses associated with litigation, to turn ERISA litigation into an endurance contest. This is contrary to the central purpose of ERISA,

which has always been intended to streamline the claims process to allow the speedy and efficient determination of claims. Miller is once again forced to go through the administrative process and appeal again, simply because Monumental improperly raised a new defense on appeal. This Court should resolve the conflict in the circuits and provide guidance to the federal courts in enforcing the rule that no new defenses can be raised on appeal, and incorporate the common law concepts of waiver and/or estoppel in ERISA cases in order to further the central purpose of ERISA.

CONCLUSION

For the foregoing reasons, the Petition for Writ of Certiorari should be granted.

Respectfully Submitted,

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JULY 2010